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WELL-ELDERLY CLINICS:

AN ALTERNATIVE TO INSTITUTIONALIZATION

PART II:

NEEDS ASSESSMENT

by Karen J. Theisen
October, 1979

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INTRODUCTION

For a number of years, federal decision-makers have either ignored the health problems of rural areas or viewed them as insurmountable. Viewed against urban problems which were both more visible and thought to be more efficiently soluble, rural health has had low priority, in terms of both the health agencies and those concerned with and involved in formulating rural development strategies.

Strides have been made in recent years to bridge the gaps for the delivery of health care in rural areas. Rural areas require new and innovative solutions and approaches to help remedy the imbalance of both physician and ancillary manpower and for health programs. Some approaches are federally funded programs for Rural Health Initiative, Emergency Medical Services, Health Maintenance Organizations, Community Mental Health, Alcohol and Drug Treatment and Rehabilitation, Health Underserved Rural Areas, Public Health Service Manpower, and Title VII nutrition projects.

The unequal distribution of public expenditures, while partly attributable to the unequal distribution of health personnel, is encouraged and sustained by the two major sources of public health dollars, Medicaid and Medicare. The design and implementation of both programs fit the financial needs of specialized, institutionally-based medical care. Such care, while the care of the urban health care system is both inappropriate and scarce in sparsely populated rural areas, is an example of the inequity in the reimbursement of ancillary health manpower in rural areas.

It has been documented that rural populations do experience high incidences of health problems and related disorders despite the belief that they have cleaner air, fresher water and better food, less stressful lives, and are healthier than their urban counterparts. Moreover, rural areas also tend to have large populations of elderly with many experiencing financial disabilities which influence cost-cutting of nutrition and health care services, inadequate transportation networks, and a lack in availability of preventive health care services which often renders them especially vulnerable to adverse environmental influences, which often results in premature institutionalization.

Due to age-related changes, many elderly people are likely to be in need of health or social services.[1] There is an increased likelihood of chronic disease, resultant social isolation and changes in lifestyle. Phsysiological, psycho-social, cultural, and spiritual factors are interrelated in the determination as to the elderly's ability to continue functioning in today's society with maximum independence. Also an important consideration is the maintenance of the quality of life.

Socio-economic conditions severely aggravate and differentiate the urban population from the rural population which contributes to health problems. In 1976, the per capita personal income in Montana ranked 34th in the nation. Poverty often means inadequate nutrition, so that the poor are susceptible to ill health. Also, there is some evidence for this conclusion in data from a survey made by the DHEW: the lower the family income,

the higher the percentage of chronic health conditions. Regardless of age, low family income has a direct relationship with a greater amount of health-related chronic limitations of activity.

The numbers of elderly persons are in general on the increase, and along with this increase come many health and service problems. These problems are receiving increasing and necessary attention by service planners, practitioners, and researchers in search of new approaches to the elderly's health care in preventing chronic disabling disease and the prevention or postponement of entering an institution. Chronic disease may be more specifically defined as a disease which has one or more of the following characteristics: is permanent; leaves residual disability; is caused by non-reversible pathological alterations; requires special training of a person for rehabilitation; or may require a long period of supervision, observation, or care.

Well-elderly clinics are one method of providing health promotion and disease prevention strategies by reducing the health risks of the elderly and providing appropriate and flexible services when and where they are needed. The concern for the elderly's access to preventive health services is emphasized in this paper, so that they may remain in good health and in the mainstream of community life. Emphasis on well-elderly clinics subsequently brings us one step closer to a viable alternative to institutionalization.

The remainder of this paper is broken into four main parts. They are: 1) Area V Study; 2) Needs Assessment; 3) Summary; and 4) Recommendations. The Area V Study describes the health status, among other issues, of rural elderly. The Needs Assessment discusses the elderly population, manpower, and services. In the Summary and Recommendations sections, gaps in the previous sections are addressed and recommendations for consideration of policy alternatives are suggested.

OVERVIEW

The pages to follow illustrate an attempt to provide much needed data in relation to the health care needs of the elderly and the need for alternatives to institutionalization. Systematic data on needs of the elderly and on needs for alternatives are virtually non-existant in Montana. Furthermore, the effectiveness of present alternatives have yet to be demonstrated in regard to availability, accessibility, quality, continuity, and cost-effectiveness. Yet, alternatives to institutionalization are today one of the most challenging and promising components of elderly health care.

Generally, well-functioning ambulatory elderly people residing in the community provide a logical target group if we consider the preventive role of non-institutionalized services. Early intervention, health maintenance and promotion, which does not promote dependency, is a key approach for meeting the varied needs of the older population in the community, and may forestall or prevent institutionalization for a significant number of persons. If this potential is to be fully realized, well-elderly clinics must be given priority in health planning.

At this time, services which have been established for the elderly are fragmented, incomplete, and in some instances, duplicative and have not been totally responsive to their multi-disciplinary needs. There must be a complex relationship formed by all those providing services for the elderly for continuous, efficient, cost-effective, preventive health care. Analysis of these relations in Montana show inadequate organization of present health care resources in many instances.

The Area V Agency on Aging is, at this time, attempting to pull together present resources for their elderly into an effective program for alternatives to institutionalization. This Area should serve as a model for the rest of the State.

It now seems obvious that the key to a successful organization of alternatives lies in the effective collaboration and coordination of services programs and agencies. Well-elderly clinics are an integral part of an overall array of services programs for the elderly. This complex network of health and related services would provide for viable alternatives to institutionalization programs with reasonable assurance that the living standard achieved during the earlier years of life may be maintained despite the increased disabilities which often accompany aging.

At the present time, a demonstration project for well-elderly clinics is being developed as an alternative to institutionalization for the elderly in Helena. The clinic, staffed by Carroll College faculty and students, is located in the congregate housing complex, Stewart Homes. Although it is at this time open only to Stewart Home's elderly, a short term goal exists to opening the clinic to the elderly in the community as well.

PURPOSE

Chronic diseases affect people in all age groups but are more prevalent in each successively older age group. Chronic conditions pose a major threat to health status, especially to those 60 and older.

Inasmuch as chronic diseases are not required to be reported, their incidence and prevalence rates are required for the purpose of designing health care services to fit the population's needs.

The primary purpose of this paper is to determine the health care needs of the elderly through data analysis to assess the need for well-elderly clinics as an alternative to institutionalization. Key information sought includes health needs as perceived by the elderly, population projections in the 50+ age group, current available health services and the utilization of those services by the elderly and manpower distribution.

Finally, recommendations are made for the purpose of filling current gaps in health care and planning.

AREA V AGENCY ON AGING NEEDS ASSESSMENT ANALYSIS

In order to determine the need for new initiatives and policy alternatives for rural health care for the elderly, it is essential to assess the status of rural health. Because data obtained from HEW's National Center for Health Statistics do support the prevalence of chronic diseases and conditions as strikingly higher in rural areas, a study was undertaken by the Montana Area V Agency on Aging to collect data on chronic disease prevalence which has been heretofore virtually unavailable in the State.

After examining the selected statistics on the health status of rural people and the current services available, the scope and adequacy of the existing health care delivery system in meeting the perceived needs of the elderly population will be assessed.

The following analysis is not comprehensive of all the strengths and weaknesses of the various components which comprise the organization of health and medical care in the State. It is, rather, an attempt to highlight significant factors which must be considered in developing future health policy. The material contained in the study should form an adequate basis for assessing perceived needs of a target group, the elderly.

Another study should be developed to evaluate the impact of various health strategies on this target population.

At the present time, Montana's Area V Agency on Aging is conducting a needs assessment to provide data on the elderly's perceived needs. The assessment is to include thirty (30) counties (See Figure 1) and one Indian Reservation. To date, results have been made available for eleven (11) counties (See Figure 2) or twenty percent of the State. Also illustrated on Figure 2 are 1970 Census populations and projected 1985 populations for people 60 years and older.

The needs assessment was conducted by VISTA volunteers utilizing personal interviews. A questionnaire containing various topics such as health, transportation, services, etc., was the basis for the personal interviews of those persons aged 60 and older. Fifteen percent of the total 60+ elderly population (n=2,853) answered one or more of the questions on the questionnaire. The data collected from the Area V survey is compared to national data obtained from HEW. National data was collected in the same fashion.

The incidence of chronic ailments or illnesses in Montana in comparison with the national average is very significant as the following table illustrates.

TABLE 1

INCIDENCE OF CHRONICITY: MONTANA vs. NATIONAL AVERAGE

Chronic Conditions	Montana (60+) [1]	National (65+) [2]
Arthritis	34.8	23.2
Heart/Hypertension	28.4	16.1
Orthopedic	20.4	3.2
Vision	16.2	9.8
Hearing	15.8	2.3
Respiratory Disease	11.1	3.3
Diabetes	7.3	6.8
Cancer	4.0	- -
Stroke	3.9	- -

1. Montana Data collected from Area V Agency on Aging.
2. National Data obtained from U.S. Dept. of HEW, Public Health Service, Vital Health & Statistics, Series 10-#111 Limitation of Activity Due to Chronic Conditions, U.S. 1974, p.18.

Although rural populations are believed to be healthier than urban populations due to cleaner air, water, etc., it was found in this survey that chronicity in those persons aged 60 and older in Montana is significantly higher than the national average.

Nationally, arthritis ranks second as an important public health concern. It is a serious, widespread and crippling chronic disorder. In Montana, according to the survey, arthritis is related as the number one chronic illness disorder by those persons aged 60 and older.

Even more striking is the ranking of orthopedic impairments. Ranked eighth nationally, orthopedic conditions present a significant health problem to Montanans as indicated by its rank and incidence. Elderly persons afflicted with orthopedic conditions in Montana is almost seven times the national average and is ranked number three. This average may be high due to the type of physical labor in relation to the area surveyed (i.e., mining, lumbering, etc.).

Of the chronic conditions, hypertension is particularly problematic. Nationally, hypertension is ranked fourth in chronicity. However, averaged with heart conditions, its ranking is second place. The ranking of same in Montana is also second, but the incidence rate of heart/hypertension disorders in Montana is significantly higher. Since high blood pressure increases the risk of developing heart disease, and heart disease ranks number one nationally as the leading cause of death, it is imperative

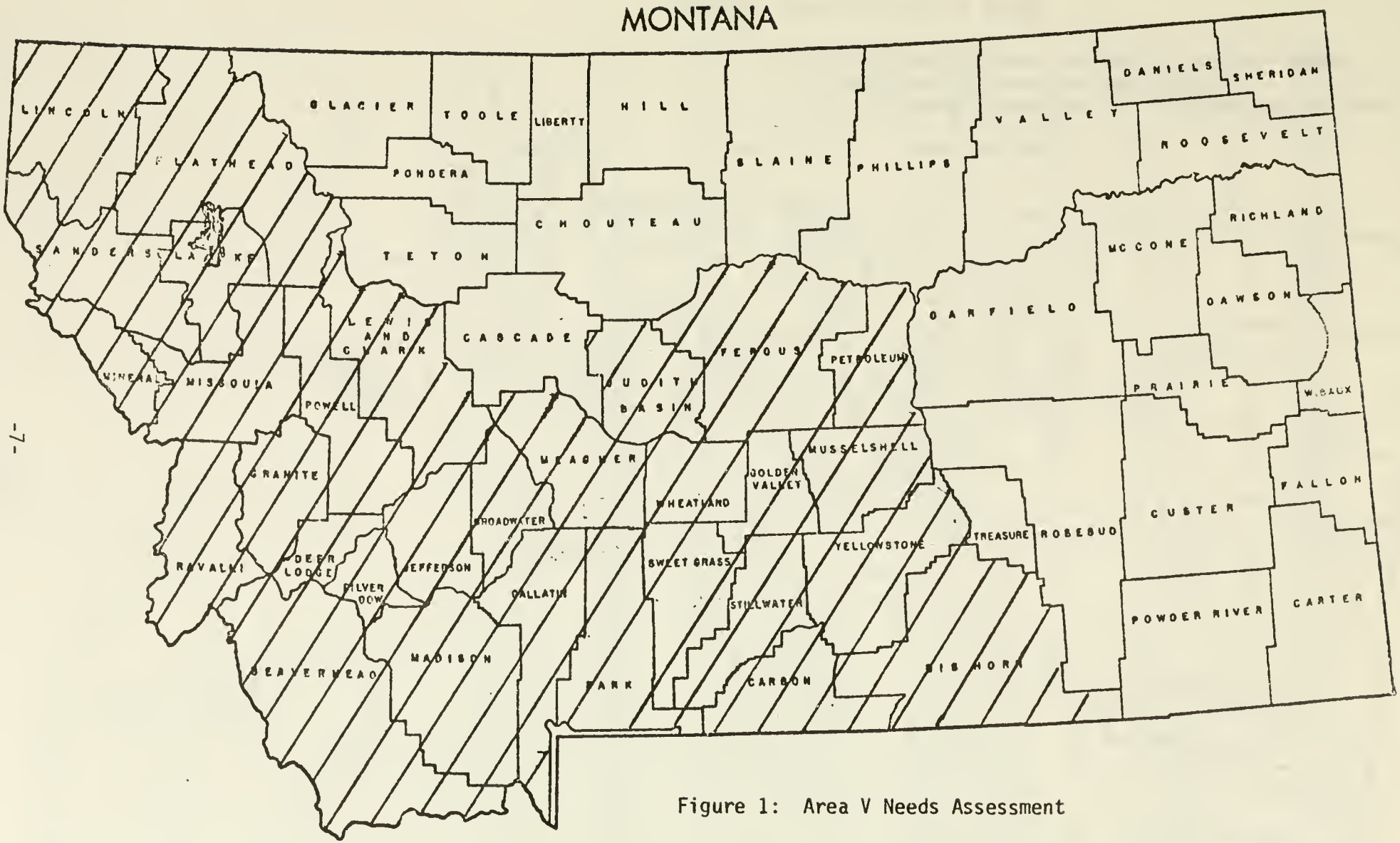


Figure 1: Area V Needs Assessment

///-Represents counties currently under study by Area V Agency on Aging

Source: Areas V Agency on Aging

MONTANA

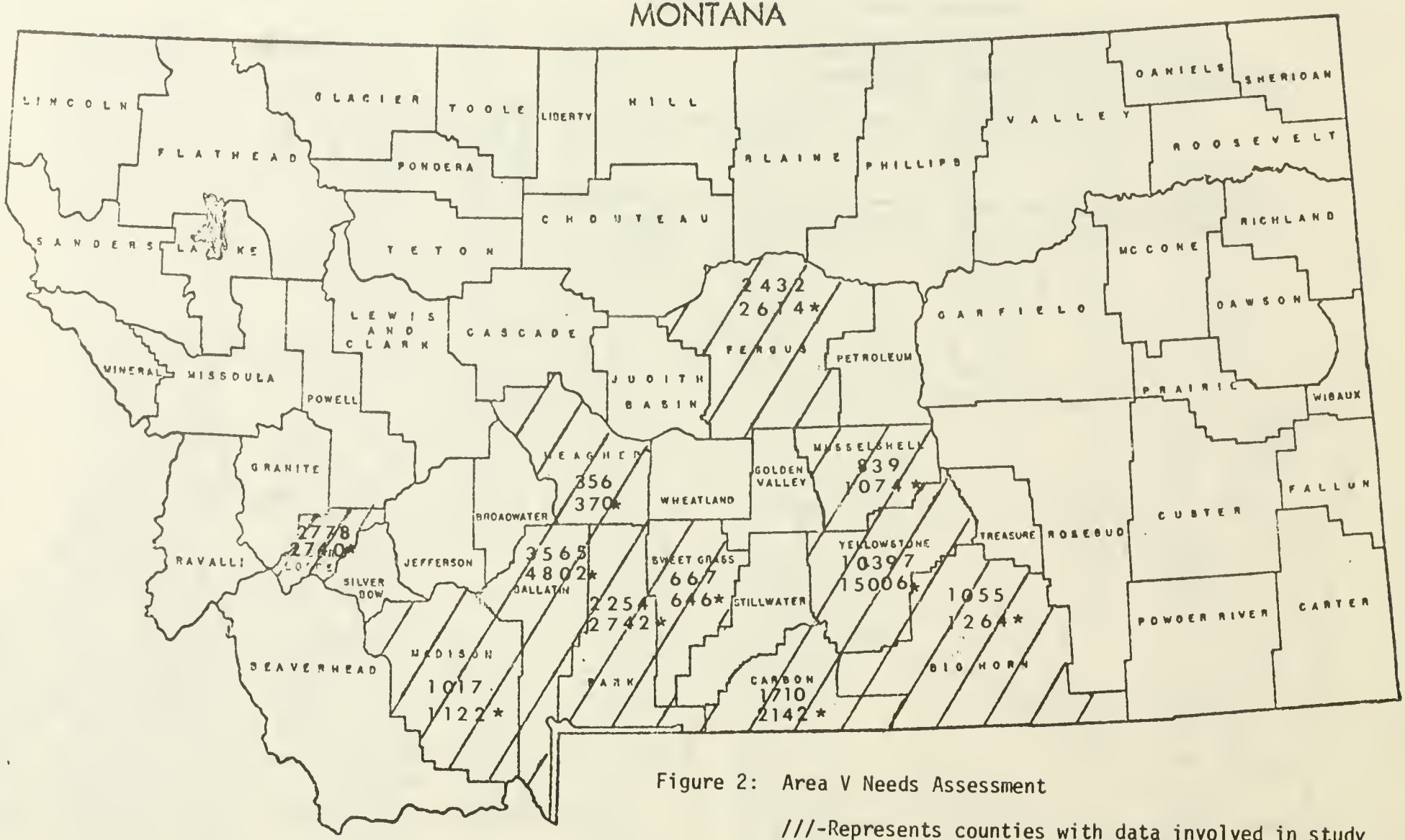


Figure 2: Area V Needs Assessment

///-Represents counties with data involved in study
Population: 60 years and over (1970)
Population: 60 years and over (1985) projected*

Source: Area V Agency on Aging

that effective management of hypertension and location of others with hypertension in Montana be considered a high priority.

Vision, hearing, and respiratory disease incidence also remains higher in Montana.

Cancer and stroke rank eighth and ninth respectively in Area V's survey. Although cancer is one of the leading causes of death in this age group nationally, it, along with stroke, was not listed in the top ten chronic disorders.

Mental and nervous conditions, which rank high in the nation's chronic illness incidence, were not recognized in the Area V study.

Overall, the survey indicated that although chronicity is high, an overwhelmingly large number of elderly are not disabled by an ailment or disease. This indicates that a large number of elderly persons are ambulatory and could benefit from ambulatory well-clinics to maintain their current level of wellness. With a continuous array of services for the elderly, nursing homes could indeed become a last resort.

Of those persons surveyed, 54 percent had seen a physician within the past year. Forty-two (42) percent had a vision check within the past two years, and the majority had a hearing test in the past five years or longer. Only 54 percent of those interviewed have readily available medical care. The reason most given for failure in attaining health care is distances to health care services. Sixty-seven (67) percent use local services, but when local services are not available, average distance to the nearest medical facility is nearly two hours (93.61 miles) away.

It was also determined by the survey that the services elderly people are aware of have a high utilization rate. These services include blood pressure clinics and social activities at the Senior Centers.

From the data presented, it can be assumed that if present programs for the elderly were to be expanded and extended to include comprehensive primary health care (well-elderly clinics) with a multi-disciplinary approach to health promotion and disease prevention, the well-elderly population today and tomorrow could maintain a state of wellness.

NEEDS ASSESSMENT

Manpower

Physicians have been and will continue to be the central figure in the health care system. For this reason, it is important to look at their distribution in Montana.

Manpower distribution is of the utmost importance in Montana. Being primarily a rural state, availability and accessibility of primary health care services is crucial for all Montanans for the prevention of early deaths, disease, unnecessary disability, and the discomfort arising from disease.

To better understand what primary health care is, the Discursive Dictionary of Health Care describes primary care as "...basic or general health care which emphasizes the point at which the patient first seeks assistance from the medical care system and the care of simpler and more common illnesses. The primary care provider also assumes responsibility for the patient in both health maintenance and therapy of illness."

Stated more simply, primary health care is the care most people utilize in most instances for most of their health care needs. In an organizational sense, primary care describes the entry point for a person into the health care system at which time the person may be referred to a more intensive or specialized service as deemed necessary.

Studies of the distribution of physicians in general have indicated that physicians tend to move toward areas of high population density. An American Medical Association (AMA) study of graduates of American medical schools shows that heavily populated communities were attracting more physicians per capita, as well as more physicians in total number. Thus, the ratio of population to physician is inversely related to total county population. As the following Figures indicate, this is also true in Montana.

TABLE 2

PHYSICIAN RATIO
(Number of Physicians per 1,000 population)

Health Service Area	Total * Population	Total Active Physicians	Ratio Population Physicians	Primary ** Care Physicians	Ratio Pop./ Primary Care Physicians
(Counties)					
AREA I.					
Carter	1,853	2	1.07	1	.53
Custer	13,524	23	1.70	9	.66
Daniels	3,023	2	.66	2	.66
Dawson	11,881	9	.75	7	.58
Fallon	4,048	3	.74	2	.49
Garfield	1,689	1	.59	1	.59
McCone	2,530	1	.39	1	.39
Phillips	5,501	2	.36	1	.36
Powder River	2,203	2	.90	2	.90
Prairie	1,895	1	.52	1	.52
Richland	11,186	12	1.07	8	.71
Roosevelt	10,761	9	.83	7	.65
Rosebud	10,870	8	.73	7	.64
Sheridan	5,019	2	.39	2	.39
Treasure	1,199	- -	- -	- -	- -
Valley	14,433	11	.76	6	.41
Wibaux	1,474	- -	- -	- -	- -
TOTAL	103,081	88	.85	58	.56
AREA II.					
Blaine	6,939	2	.28	2	.28
Cascade	85,112	146	1.71	56	.65
Choteau	6,266	2	.31	2	.31
Glacier	11,514	12	1.04	10	.86
Hill	18,421	24	1.30	13	.70
Liberty	2,561	2	.78	1	.39
Pondera	7,106	6	.84	3	.42
Teton	6,979	7	1.0	5	.71
Toole	5,042	5	.99	4	.79
TOTAL	149,940	206	1.37	96	.64

Health Service Area	Total * Population	Total Active Physicians	Ratio Population Physicians	Primary ** Care Physicians	Ratio Pop./ Primary Care Physicians
AREA III.					
Big Horn	11,716	7	.59	5	.42
Carbon	8,112	5	.61	5	.61
Fergus	13,112	18	1.37	10	.76
Golden Valley	879	- -	- -	- -	- -
Judith Basin	2,631	- -	- -	- -	- -
Mussellshell	4,367	2	.45	2	.45
Petroleum	679	- -	- -	- -	- -
Stillwater	5,486	3	.54	3	.54
Sweetgrass	2,907	3	1.03	3	1.03
Wheatland	1,977	3	1.51	3	1.51
Yellowstone	109,073	199	1,82	100	.91
TOTAL	160,939	240	1.49	131	.81
AREA IV.					
Beaverhead	8,703	7	.80	4	.45
Broadwater	3,011	3	.99	3	.99
Deer Lodge	14,839	22	1.42	11	.71
Gallatin	40,501	67	1.65	42	1.03
Granite	2,656	1	.37	1	.37
Jefferson	7,269	6	.82	5	.68
Lewis & Clark	40,930	92	2.24	50	1.22
Madison	5,602	4	.71	3	.53
Meagher	2,198	1	.45	1	.45
Park	12,991	13	1.0	8	.61
Powell	8,030	9	1.12	7	.87
Silver Bow	43,110	57	1.32	22	.51
TOTAL	189,839	282	1.48	157	.82
AREA V.					
Flathead	49,095	78	1.58	46	.93
Lake	18,212	20	1.09	14	.76
Lincoln	15,874	15	.94	12	.75

Health Service Area	Total * Population	Total Active Physicians	Ratio Population Physicians	Primary ** Care Physicians	Ratio Pop./ Primary Care Physicians
AREA V.(Continued)					
Mineral	3,809	3	.78	3	.78
Missoula	71,248	168	2.35	75	1.05
Ravalli	19,331	15	.77	9	.46
Sanders	8,653	5	.57	4	.46
TOTAL	186,222	304	1.63	163	.87

* Based on DCA 1980 projected population.

** Number of Primary Care Physicians (Medical Doctors and Doctors of Osteopathy) as of January 1979. Primary Care includes Family Practice, General Practice, Obstetrics and Gynecology, Pediatrics, and Internal Medicine Specialties.

Nationwide, there is a significant geographic maldistribution of physicians. An AMA study reports that there are more than twice as many physicians per 100,000 population in metropolitan areas as are in non-metropolitan areas. The following chart illustrates this along with a comparison of a populated county and rural county in Montana.

TABLE 3

AMA		Ratio	MONTANA	Ratio
Area:	Metropolitan	1.46	Missoula City	2.35
	Non-Metropolitan	.69	Blaine County *	.28
	(Physicians per 1,000 population)			

The above is only one example of several geographic maldistribution problems in Montana. Overall, rural counties have a substantially higher population to physician ratio. In several counties, there are no physicians.

Medical Economics has set guidelines for physician ratios. For primary health care, it is recommended there be .89 primary care physicians per 1,000 population. As shown in Table 2, 83.9 percent of the counties in Montana do not meet the recommended ratio.

Primary care specialists (Internists, Pediatricians, Obstetricians, and Gynecologists) are, for the most part, located in the larger counties in Montana (i.e., Missoula, Lewis & Clark, Yellowstone).

The ratio for total physician supply is recommended at 1.48 physicians per 1,000 population. In Montana, only 10.7 percent of the counties meet this recommended ratio.

Those counties which do meet the recommended ratio are again the most populated areas in Montana.

Overall, many rural people in Montana do not have readily available health care services. Many will find they must travel great distances to find medical care--especially in specialty areas.

If there are relatively few physicians in an area, it may be difficult for a person to see doctors who may already have more patients than they can handle. We need to re-examine the health manpower needs and ways of organizing the health care delivery system. This may mean the licensing and reimbursement of nurses and other allied health professionals in clinics where there is not an on-site physician to constantly supervise, but would be within a reasonable distance to provide for back-up assistance. (See Recommendations)

* Includes Indian Health Service

Population Projections

An awareness of the numbers and projected numbers of target populations is necessary to offer a general framework within which to plan and implement services for that target population. In this instance we are looking at the population 50 and older, as they are particularly vulnerable to chronic disease due to age-related changes. Early disease detection and health maintenance of this group is essential to maintain a steady state of wellness.

The 1970 census age cohorts were utilized to obtain population projections of those persons aged 50 and older in Montana, since other data sources were not age specific. The 1980 cohorts were calculated by using "straight line" estimates derived from the 1970 census cohorts.

Since this method does not adjust for mortality and migration, the final county total estimates were compared to independent non-cohort specific estimates calculated by other agencies. The comparison made, using Medicare enrollment data provided by the Health Care Financing Administration, indicated little or no variation with our estimates.

Nationally, elderly persons are increasing both numerically and proportionally. Census data documents well those increases.

In Montana the growth rate of persons aged 50 and over is decreasing slightly as the following Tables illustrate. However, the absolute numbers are increasing.

The following Table illustrates the population projections of persons 50 and older in the eleven counties which have been analyzed in Area V's study.

TABLE 4

COUNTY	1970			1980			1985		
	50-59	60-64	65 +	50-59	60-64	65 +	50-59	60-64	65 +
Big Horn	988	362	693	2,313	403	824	2,617	373	891
Carbon	981	479	1,231	816	541	1,418	761	731	1,411
Deer Lodge	2,245	901	1,877	2.078	610	2,022	2,192	565	2,175
Fergus	1,402	586	1,846	1,330	507	2,010	1,376	553	2,061
Gallatin	2,852	947	2,618	3,402	1,148	3,290	3,775	1,123	3,679
Madison	666	290	727	678	258	878	648	283	839
Meagher	272	117	239	270	95	273	283	82	288
Musselshell	496	231	608	382	337	641	372	420	654
Park	1,411	601	1,653	1,162	838	1,773	1,381	855	1,887
Sweetgrass	411	173	494	363	99	549	301	167	479
Yellowstone	8,822	3,333	7,064	10,632	3,851	9,128	12,363	4,404	10,602
TOTALS	20,546	8,020	19,050	23,426	8,689	22,806	26,069	9,556	24,966
TOTAL POP.	190,319			225,418			250,368		
% TOTAL POP.	10.79	4.2	10.0	10.39	3.85	10.1	10.41	3.81	9.97

The following Table is the population and projected population 50 and older in the five planning regions in Montana. *

TABLE 5

DATE	REGION	TOTAL POP.	AGE GROUPS 50 - 64	AGE GROUPS 65 +	% TOTAL POP. 50 - 64	% TOTAL POP. 65 +
1970	I	91,756	13,832	9,956	15.0	10.7
	II	144,070	19,439	12,457	13.4	8.6
	III	135,263	20,427	13,513	15.1	9.9
	IV	129,317	27,106	17,998	20.9	13.9
	V	154,691	21,528	14,914	13.9	9.6
1980	I	103,099	14,380	11,139	13.9	10.8
	II	149,940	19,259	14,676	12.8	9.7
	III	160,759	23,496	16,335	14.6	10.1
	IV	189,840	26,732	20,364	14.0	10.7
	V	186,222	24,435	18,793	13.1	10.0
1985	I	108,714	15,678	11,914	14.4	10.9
	II	156,766	20,291	14,953	12.9	9.5
	III	180,819	26,463	17,900	14.6	9.8
	IV	205,798	28,926	21,417	14.0	10.4
	V	206,093	27,440	20,461	13.3	9.9

* Montana Population Projections, 1975-2000, DCA Unpublished data: SHPDA (Medium Series)

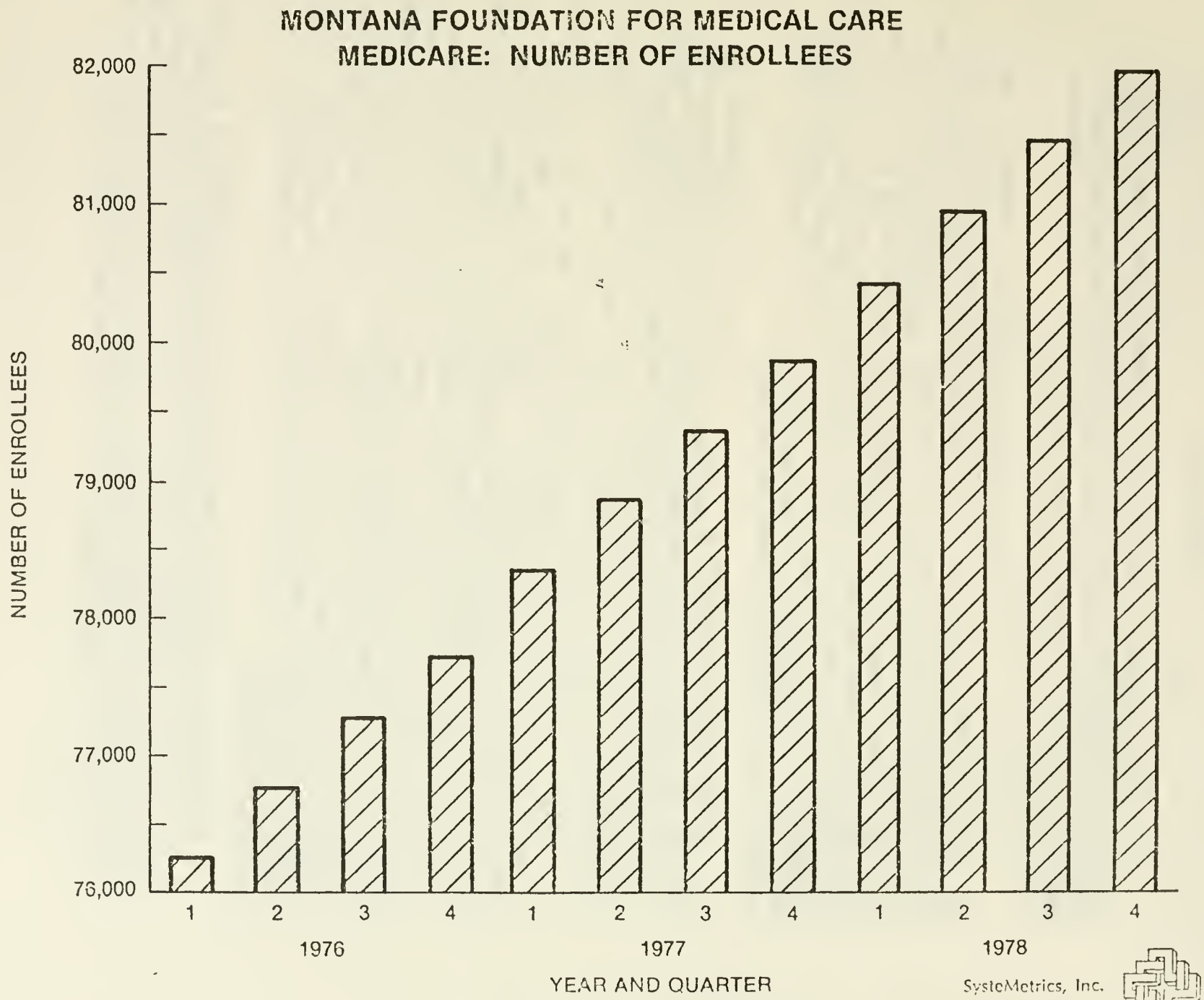
Table 4 shows an overall slight decline in the percentage of the total population of those aged 50 and over. The same holds true for Table 5.

This decrease in the percent of total population in the cohorts utilized is due in part to the increase in the 18-64 age group. This "bulging" skews the data in the older age groups. Although the decline illustrated is slight, the numerical growth of the elderly population is significant. For example, between 1970 and 1985, Region V has a projected increase of 5,547 elderly in addition to the 14,914 elderly population 65 and older. In the cohort 50-64, there is also a projected increase of 5,912 in addition to 21,528 elderly in the 1970 census. This increase in the numbers of elderly persons is projected for all five regions.

The significant growth numerically of the elderly indicate a larger target population in which health care services must be designed to provide for optimal well-being. These services can be designed to help the elderly achieve, maintain, or support the highest possible degree of independence and self-sufficiency by including well-clinics, education, manpower, social services, nutrition, and housing services.

Also significant is the increase in enrollees in the Medicare aged program. Figure 3 illustrates that increase. The reimbursement of nurses and other allied health professionals for cost-effective preventive health must be looked at for possible revision to allow reimbursement of physician extenders for preventive measures of this growing target population.

FIGU 3


MONTANA FOUNDATION FOR MEDICAL CARE
MEDICARE: NUMBER OF ENROLLEES
NUMBER OF ENROLLEES
82,000
81,000
80,000
79,000
78,000
77,000
76,000
1
2
3
4
1
2
3
4
1
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3
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1976
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YEAR AND QUARTER
SysteMetrics, Inc.

CONCLUSIONS

Due to time limitations and the lack of systematic data regarding the health status of Montana's elderly and cost-effectiveness of alternative programs, a preliminary review has been accomplished. As more data becomes available, this report should be updated and validated. Based on the preliminary review, the following conclusions are made.

The inefficiency of the health care delivery system in Montana to meet the varied and complex needs of its rural population is a serious one. Although strides have been made to alleviate some of these inefficiencies, a population exists where more must be accomplished. Nationally, and in Montana, the elderly population is increasing numerically, and proportionally to the total population. People are living longer, many maintaining a high level of wellness, while others are maintained in an institutional setting. There are complex needs which must be met in an attempt to enable more elderly to live independently longer and in good health. However, these needs have not been determined in a systematic way in Montana; there is a preliminary basis being developed which needs further study and analysis.

The Area V Agency on Aging is at this time attempting to determine the needs of the elderly population in Montana by directing a needs assessment. Although the study is not yet completed, results thus far indicate a higher chronicity rate in Montana than the national average. This preliminary data should provide impetus for further studies on a local level of chronicity rates and other needs and to reexamine the overall health status of Montanans.

There is a need for a full array of interrelated services for the elderly in an attempt to avoid or allay institutionalization. Due to age-related changes, the elderly undergo many crises. A simple intervention often aids the individual to cope with other problems independently. This independence along with health care maintenance will enable an individual to maintain a high level of wellness. A simple task? Unfortunately, due to the geographic and specialty maldistribution of physicians in Montana, and the high cost of medical care, many elderly do not have access to or can financially afford such preventive services. Continuous, available, affordable, and efficient preventive health care services are not a reality in Montana. For this reason, the establishment and reimbursement of well-clinics manned by nurses and other allied health professionals is one viable alternative to the present situation. The capabilities and effectiveness of such a program should be demonstrated and evaluated in Montana.

Evaluation is an important consideration in the development of any program. It can serve many functions. Evaluation demands that relationships between program variables and desired outcomes be clarified. It also serves a quality control function in monitoring a program. Finally, evaluation of a program can determine whether the services provided resulted in improvements in the functioning of clients or in the prevention of further decline in functioning.

Well clinics for the elderly are proposed for an integral part of an alternative's program for the elderly. There is a need for practitioners and planners to work together and to fully realize the elderly's needs and the available community services to meet those needs in the development of such clinics so that timely interventions can be provided for the elderly by agencies in full cooperation with one another.

RECOMMENDATIONS

1. A uniform reporting system should be instituted for gathering information on health care services. This system would alleviate unnecessary duplication of health care services and denote needs for alternatives to institutionalization.

2. A system of linkages must be established to bridge the gaps in health and social services for better information and referral at the local level.

3. Additional research and study is needed on the health status profile of Montanans aged 50 and older in each region of the State. Emphasis must be placed on chronic incidence rates. This planning would then ensure meeting the needs of a diverse population in program planning.

4. Further studies are to be undertaken on manpower distribution to include physician extenders and other allied professionals to meet the needs of the elderly. Reimbursement for nurses and allied health professionals must also be reviewed for a viable cost-effective alternative to physician maldistribution.

5. Well-elderly clinics will be an integral part of an array of health services in the health care delivery system. The clinics will be located in accessible areas such as Senior Citizen Centers or congregate housing complexes. Emphasis is to be placed on health promotion and disease prevention in relation to all dimensions of man to provide for holistic services. The clinics must be readily available, accessible, acceptable, continuous, and maintain high quality primary health care at a reasonable cost.

6. Local involvement must be integrated in health planning which can help foster linkages, necessary resources, and to aid in establishing alternative modes of health care to help alleviate the needs of a target population.

7. Include the elderly in planning their own health needs to enable them to have an element of control over their lives.

8. By January 1, 1981, a one year cost-analysis and evaluation of all existing alternatives to institutionalization program must be in report form.

9. Encourage and offer technical assistance for the development of an evaluation component for the Carroll College demonstration project of a well-elderly clinic implemented by the Nursing Department. This component will study the cost-effectiveness and utilization rates of their program.

10. Gather and present data regarding the needs of the elderly and preventive health clinics to the legislature to promote funding for alternatives to institutionalization programs.

FOOTNOTES

1. Karen Theisen, Well-Elderly Clinics: An Alternative to Institutionalization. Boulder, Colorado, Western Interstate Commission for Higher Education, 1979.

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4. Montana Population Projections, 1975-2000, Montana Department of Community Affairs, Capitol Station, Helena, Montana, August, 1977.

5. Montana State Health Plan, Montana State Department of Health and Environmental Sciences, Helena, Montana, May, 1979.